# MEMORANDUM

**May 2, 2008**

**To:** **Republican Members of the Committee on Oversight and Government Reform**

**From:** **Committee on Oversight and Government Reform Republican Staff**

**Subject:** **Full Committee Hearing on "The Lack of Hospital Emergency Surge Capacity: Will the Administration's Medicaid Regulations Make it Worse?"**

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On May 5, 2008, at 10:00 a.m., in Room 2154 of the Rayburn House Office Building and on May 7, 2008, at 9:30 a.m., in Room 2154 of the Rayburn House Office Building, the Committee will hold two days of hearings to examine emergency preparedness and hospital surge capacity.

The Majority intends for the hearings to focus on the impact of Medicaid regulations, however the factors impacting medical surge capacity in a catastrophic event are complex and more dynamic than simply tying it to the current day-to-day emergency department (ED) capacity concerns. Furthermore, gaps that may exist in medical surge capacity are more appropriately addressed through targeted investments than national reimbursement policy.

Finally, this memo includes information regarding the relevant homeland security directives that may be referenced in Wednesday's hearings. Part of the Majority's premise is that the proposed Medicaid regulations are contrary to the Department of Health and Human Services responsibility as the lead federal agency for medical preparedness. These documents may be used to articulate that argument.

## I. FACTORS INFLUENCING MEDICAL SURGE CAPACITY IN A CATASTROPHIC EVENT

Medical preparedness for a catastrophic event involves a number of factors at the local, state, and federal government. The Centers for Disease Control and Prevention (CDC) convened an expert panel and authored a report defining the factors influencing

medical surge capacity under the scenario similar to the Madrid and London terrorist attacks.[1] In the case of Madrid on March 11, 2004 ten terrorist bombs were detonated in commuter trains killing 177 people instantly and injuring more than 2,000. The nearest hospital received 272 patients within two and half hours.

Under this type scenario, the CDC report found 9 components that may determine the success of responding to a Madrid-like event, including:

1. Functional leadership structure with clear organizational responsibilities.

2. Standards of care may need to be altered in order to have the largest number of possible survivors. The Agency for Healthcare Research and Quality (AHRQ) released an expert report on this matter and found that in a catastrophic event many hospitals and health systems are unprepared to deal with the ethical and legal issues surrounding the allocation of scarce resources to maximize lives saved.[2]

3. With the exception of emergency medicine, physicians and other health care professionals are not trained and educated in basic disaster preparedness and response. Proper response to catastrophic event will require the involvement of all health care professionals.

4. Effectively and timely communications are vital to a coordinated response. A catastrophic event will require response from multiple hospitals and health care systems that may not have established communication protocols to determine the availability of resources. Additionally, traditional communication systems may be damaged in the attack requiring backup communication systems. Virginia and other states have instituted bed and patient tracking systems for this purpose.

5. Coordinated transportation will be required because the need to involve trauma centers and other tertiary care hospitals to care for a large number of victims.

6. All hospitals infrastructure and capabilities in a region will be involved in responding to a catastrophic attack, which will require having sufficient personnel, equipment and supplies, and prior commitment of resources to stockpile certain items.

7. While emphasis is often place on ED, other areas of clinical care can be potential bottlenecks in hospitals ability to provide care. In particular limited radiology capacity (in Madrid 350 radiology studies were performed in one day), intensive care unit (ICU) beds, pharmaceutical supplies are all areas that can delay appropriate care.

[1] National Center for Injury Prevention and Control, *In a Moment's Notice: Surge Capacity for Terrorist Bombings* (Centers for Disease Control and Prevention, 2007).
[2] *Altered Standards of Care in Mass Casualty Events* (Agency for Healthcare Research and Quality, 2005).

8. Prehospital triage will remain important in a catastrophic event, however in such instances patients often walk to the nearest hospital or are transported by non-emergency personnel. This can be challenging because patients may not end up at the most appropriate site of care and it has been documented that victims who are note seriously injured still may seek out care because of the shock of the event.

9. Legal issues may be implicated in a catastrophic event including credentialing of medical providers, the Emergency Medical Treatment and Active Labor Act (EMTALA), and the Health Insurance Portability and Accountability Act (HIPAA).

It is important to recognize the complexity of issues that contribute to medical surge capacity in a catastrophic event. While individual hospital's ED capacity is a factor (#6) it is by no means the only factor that determines preparedness. It is not appropriate to make conclusions about medical surge capacity and preparedness based solely on ED capacity at level 1 trauma centers.

## II. DAILY CAPACITY VS CATASTROPHIC SURGE CAPACITY

The Institutes of Medicine (IOM) 2006 report *Emergency Medical Services at the Crossroads* found that the emergency medical system is overburdened, underfunded, and highly fragmented.[3] ED crowding can result in boarding, which is when a patient requires an inpatient admission but there are not inpatient beds available so the patient is boarded in the ED. ED crowding can also result in ambulances being diverted to other hospitals for care.

IOM found that these practices are the result of poor system wide integration between and hospital management practices. It is not unusual for hospitals to utilize inpatient beds for elective surgeries, which have a more favorable reimbursement, instead of using those beds to move patients out of the emergency department. In particular the report found that under the payment system there are few financial incentives for hospitals to reduced ED overcrowding. Additional research has found that ED admissions are among the lowest priorities in many hospitals and those on-call specialists are more frequently opting out of emergency coverage.[4]

While the difficulties facing emergency departments on a daily basis are well documented, their implications for catastrophic surge capacity are not as clear. In 2006, the Society for Academic Emergency Medicine held a consensus conference on "The Science of Surge" that evaluated both daily capacity and catastrophic surge capacity.[5] A resulting article from the conference the differences between day-to-day ED operational capacity versus catastrophic in the following way:

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[3] Institute of Medicine Committee on the Future of Emergency Care in the U.S. Health System, *Hospital Based Emergency Care: At the Breaking Point* (The National Academies Press, 2006).
[4] *The Science of Surge* (Society for Academic Emergency Medicine, 2006).
[5] *Id.*.

> "Daily surge is predominantly an economic hospital-based issue, with much of the problem related to inpatient capacity but with the consequences concentrated in the ED. By contrast, catastrophic surge has significantly more components…The broader public health system is frequently involved, as are community infrastructure, regional (even national) assets, and political institutions."[6]

The current overburdened emergency medical system does not lend well to catastrophic response. However, day-to-day problems do not necessitate that the medical system does not have surge capacity in the event of a catastrophic event. Since 9/11 health systems and all levels of government have been working to develop a tiered system by which when local hospital resources are exhausted in emergency regional assets are brought to bear followed by state and federal resources. This type of system allows local hospital capacity to be greatly enhanced in a large scale emergency. In fact, on Monday's hearing, Lisa Kaplowitz, M.D. and Deputy Commissioner for Emergency Preparedness and Response, Virginia Department of Health can and will testify to the state of readiness should a mass casualty event occur in the State of Virginia. She is prepared to tell this Committee that Virginia, in the event of a disaster, is able to handle surge and should they become overwhelmed has in place plans to call upon other states and the federal government if need be.

## III. RELEVANT DOCUMENT SUMMARIES

### National Response Framework (NRF)

The NRF is the federal guide to how the nation should respond to any type of natural disaster, accident, or attack. (This is termed an "all-hazards" approach.) The NRF is always in effect and describes specific authorities and best practices for managing these incidents. The type of events addressed by the NRF range from serious but purely local, to large-scale terrorist attacks or catastrophic natural disasters. The NRF incorporates recent lessons from Hurricane Katrina and builds upon the National Incident Management System created by HSPD 5 in 2003. If necessary, only some elements of the Framework can be implemented and the response can be scaled to the extent of the emergency. The NRF includes 15 "Emergency Support Function" (ESF) annexes and eight support annexes which provide additional guidance to ensure a unified response. Summaries of the two ESFs applicable to today's hearing are included below.

### Emergency Support Function 6 (ESF-6)

ESF-6 specifies how Federal mass casualty care, assistance, housing, and human services will be delivered in the event of an emergency. The agencies primarily responsible for coordinating ESF-6 are DHS and FEMA, but they are directed to work in close coordination with state, local and tribal governments as well as volunteer groups

[6] *The Science of Surge* (Society for Academic Emergency Medicine, 2006).

and the private sector. Response activities are to focus on the needs of the victims and to be managed at the lowest possible organizational level.

**Emergency Support Function 8 (ESF-8)**

ESF-8 outlines the mechanism for coordinated Federal assistance to supplement state, tribal, and local resources in response to a **public health or medical disaster. HHS is the primary agency responsible for ESF-8 coordination and implementation**. The type of potential assistance is broadly defined and can include behavioral and psychological health services in addition to treatment for physical maladies.

**Homeland Security Presidential Directive 5 (HSPD-5)**

HSPD-5 is a Presidential directive which requires the Federal government to maintain a comprehensive national "all hazards" plan to ensure all levels of government work together efficiently and effectively to manage any incident. The DHS Secretary is charged with developing the plan. The directive specifies that responsibility for managing incidents will still generally fall to state and local authorities, until and unless they become overwhelmed. If that becomes the case, Federal entities will provide assistance. HSPD-5 mandates that in this event, the DHS Secretary will serve as the principal Federal official responsible for coordinating the Federal response. The plan treats crisis management and consequence management as a single, integrated function. **The document also outlines the roles of other cabinet secretaries.**

**Homeland Security Presidential Directive 21 (HSPD-21)**

HSPD-21 is a Presidential directive which mandates a national strategy for delivering health and medical care, especially in the case of a catastrophic event (any natural or manmade incident which results in a sufficient number of victims to overwhelm the immediate capabilities of local healthcare providers). Like ESF 8, HHS is the primary agency responsible for the implementation and coordination at the Federal level of most of the delineated responsibilities. Individual Federal agencies are also tasked with certain specific responsibilities, such as monitoring the health of large groups of potential affected individuals ("bio-surveillance"), stockpiling drugs or treatment supplies, communicating danger information, and treating large numbers of victims "mass casualty care").

**National Incident Management System (NIMS)**

The National Incident Management System is a FEMA program which establishes a mechanism to coordinate the activities of emergency responders from various jurisdictions, disciplines, and levels of government. It is intended to provide a unified response to incident management and well as standardized command procedures. NIMS is intended to be instituted only when emergency situations cannot be handled by only the affected locality, such as major incidents which require assistance from other jurisdictions, as well as state and federal governments. NIMS emphasizes preparedness

and resource sharing. NIMS is overseen by a FEMA organization known as the National Integration Center (NIC) Incident Management Systems Integration Division. NIC provides guidance and support to jurisdictions and incident management and responder organizations.

**The Emergency Management Assistance Compact (EMAC)**

EMAC is an agreement between all fifty states, the District of Colombia, Puerto Rico, Guam, and the Virgin Islands meant to facilitate fast, flexible, and legally binding sharing of equipment and resources in the event of major disasters. It is administered by the National Emergency Management Association, an organization of comprised of emergency management agencies from every state and territory. EMAC was codified by Congress in 1996.